Public Employees Health Program, FLEX$ Claims
560 East 200 South, Suite 100, Salt Lake City, Utah 84102-2004
801-366-7503 TOLL FREE 800-753-7703
FAX 801-366-7772 TOLL FREE 800-759-8772

MURRAY CITY
FLEXIBLE REIMBURSEMENT PROGRAM (FLEX$)
CLAIM FORM

PLAN YEAR FROM JAN 1 TO JUN 30

EMPLOYEE INFORMATION		
EMPLOYEE NAME (last, first, middle initial)	ID#	**PLAN YEAR:**
HOME ADDRESS CITY/STATE/ZIP		DAYTIME PHONE

Please complete **ALL** applicable spaces. Enclose *copies* of **ONE** of the following documents for each item claimed: An Explanation of Benefits (EOB) from your insurance company, **OR** a receipt/statement detailing the services provided, date of service and the total out-of-pocket expense. Indicate the item number to which they pertain. Include a Doctors note when required. Consult the FLEX$ Handbook for items requiring a Doctor's note. (www.pehp.org). The first orthodontia claim must include a copy of the written agreement between you and the orthodontist, indicating the total estimated charges and the period of treatment. **Please keep a copy of each claim for your records.**

QUALIFIED HEALTH CARE EXPENSES

ITEM NO.	DATE OF SERVICE	NAME OF PROVIDER	EXPENSE DESCRIPTION	CLAIM AMOUNT
1				
2				
3				
4				
5				
6				
7				

Claims must be for services performed within the Plan Year or the Plan grace period (Sept. 15) **TOTAL**

1. A FLEX$ HANDBOOK WITH DETAILED PLAN RULES AND INFORMATION IS AVAILABLE AT www.pehp.org.
2. YOU HAVE 90 DAYS FROM THE END OF THE PLAN YEAR TO FILE CLAIMS FOR THE PRIOR PLAN YEAR.
3. IF YOU RETIRE OR TERMINATE FROM EMPLOYMENT, YOU HAVE 60 DAYS TO FILE CLAIMS FOR EXPENSES INCURRED PRIOR TO YOUR TERMINATION DATE.

QUALIFIED DEPENDENT DAY CARE EXPENSES

ITEM NO.	DATE OF SERVICE	NAME OF PROVIDER	PROVIDER TAX ID/SSN (Required)	CLAIM AMOUNT
1				
2				
3				
4				
5				

Claims must be for services performed within the Plan Year or the Plan grace period (Sept. 15) **TOTAL**

I, the undersigned, hereby certify that the expenses for which reimbursement is sought herein are expenses that I, the Participant believe in good faith are Qualified Health Care Expenses and/or Qualified Dependent Day Care Expenses during the Plan Year for myself, my spouse and/or my legal dependents. I also certify that these expenses have not and will not be claimed for reimbursement under any other Flexible Spending Plan, insurance plan, paid for using the Flex$ card or claimed as a deduction on a tax return.

EMPLOYEE SIGNATURE	DATE	PEHP APPROVAL

Unsigned claims will not be processed.

The employer and the Plan Administrator reserve the right to verify to their satisfaction all claimed expenses prior to reimbursement and to refuse any amounts that are not Qualified Health Care Expenses and/or Qualified Dependent Day Care Expenses.